Complete this page on ALL reports.

State of California
Department of Industrial Relations
Self Insurance Plans
2265 Watt Avenue, Suite 1
Sacramento, CA 95825
Web site http://sip.dir.ca.gov
E-mail: sip@dir.ca.gov

PRIVATE SELF INSURER'S ANNUAL REPORT

	I. GENERAL		
1. CERTIFICATE NUMBER: Active Revoked	2. PERIOD OF R Full Year		port for the Period of: Year to Month Day Year
3. NAME OF MASTER CERTIFICATE HOLDER:		State of Incorpo	
NAME		Federal Tax Ide	entification No.:
ADDRESS CITY STATE	ZIP + 4	First 4 Digits of Industrial Class	f Your Standard iffication (SIC) Code:
4. List names of ALL separate, but affiliated or subsidiar (do not include DBAs or operating divisions):	ry companies cover	ed by this certificate STATE OF	SUBSIDIARY/AFFILIATE
(Continue on rever	rse side of this page it	INCORPORATION IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	CERTIFICATE NUMBER
with respect to the Master Certificate Holder or any states (a) Reincorporating (b) Merger (c) Change in Identity (d) Any additions to Self Insurance Program If yes, explain:		Yes No No Yes No No No	
(Continue on rever	rse side of this page it	f necessary.)	
6. TO WHOM DO YOU WANT CORRESPONDENCE ADDRESS.			
ADDRESS: CITY: TELEPHONE: () E-MAIL ADDRESS:	STATE: _ FACSIMILE (FA	ZIP+4: X) NUMBER: ()

SUBMIT TWO (2) COMPLETE REPORTS OF PAGES 1 THROUGH 6, INCLUDING:
• LIST OF OPEN INDEMNITY CLAIMS
• SPECIFIC EXCESS INSURANCE POLICY COVERAGE PAGE

REPORT IS DUE MARCH 1, 2001

4. (Continued)		
4. (Continued) FULL LEGAL NAME	STATE OF INCORPORATION STATE	SUBSIDIARY/AFFILIATE CERTIFICATE NUMBER
5. (Continued)		

NOTE: Claims Administrator

Complete this page for ALL reports except Item B Employment/Wages, which is completed by Self Insured Employer.

	II. CONSOLIDATED LIABILITIES						
Certific	ate Num	nber:					
Name o	of Maste	r Certificate Holder	r:				
Type of	Report:						
Ori	ginal Re	eport (Due March e	ach year)	Amended Rep	oort Inter	rim Report	
A. CASES	AND B	SENEFITS (to near	rest dollar)		From Date: Month Day	Year Date: Mon	th Day Year
		Incurred	Liability	Paid	to Date	Future 1	Liability
	Number	\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical
1. Cases open as of 12/31/2000 reported prior to 1996							
2. Open & Clo	osed Cases	:					
reported in 1996						<i>(////////////////////////////////////</i>	<i> </i>
1996 Cases open							
b. All cases reported in 1997							<i> </i>
1997 Cases open							
c. All cases reported in 1998							<i> </i>
1998 Cases open							
d. All cases reported in 1999							<i> </i>
1999 Cases open							
e. All cases reported in 2000							//////////////////////////////////////
2000 Cases open							
						\$ Indemnity	\$ Medical
					SUBTOTAL		
3. ESTIM	IATED 1	FUTURE LIABIL	TTY (Indemnity pl	us Medical)	TOTAL	\$ Indemnity	\$ Medical
4 Total	4. Total Benefits paid during 2000 (including all case expenditures):						ψ tvicuicui
		-		_			
6. Numbe	er of IN	DEMNITY cases r	eported in 2000: .				
7. TOTA	L of 5 a	nd 6 (also entered	in 2e above):				
8. TOTA	L numb	er of open indemn	ity cases (all year	rs):			
9. Numbe	er of Fa	tality cases reporte	ed in 2000:				_
				or administrator v r legal representa	vas tive in 2000:		
		•		loyer or administra			
n	otified (of representation	by an attorney o	r legal representa	tive in 2000:		
B. EM	IPLOY	YMENT AND V	VAGES PAID	IN CALENDA	R YEAR 2000:		
` '				California ampla		Voor 2000)	
	•			•	yment in Calendar	,	
(b)				\$ for all four quarte	ers)	_	

TΤΔ	ADI	MINISTR	ATOR

A. NAME OF CURRENT ADMINISTRATOR(S)	/ADMINISTRATING AGENCY(S) AT T	THE TIME OF PREPARING THIS REPORT.
1. Name (Person)		Administrative Agency's
Agency Name		Certificate No.:
Address		or Self Administered
City	_ State Zip+4	
2. Name (Person)		Administrative Agency's
Agency Name		Certificate No.:
Address		or Self Administered
City	_ State Zip+4	
3. Name (Person)		Administrative Agency's
Agency Name	_	Certificate No.:
Address		or Self Administered
City	_ State Zip+4	
4. Name (Person)		Administrative Agency's
Agency Name		Certificate No.:
Address		or Self Administered
City	_ State Zip+4	
C. NAME OF PRIOR ADMINISTRATOR(S)/A Name Agency Name Address	☐ Ch	ange in Administrative Agency ange to or from Self Administration
	- State Zip+4	
I declare under penalty of perjury that I have consolidated report of this self insurer's worker is true, correct and complete with respect to the the penalty of perjury that the estimates of further administrator's best judgment as to the future intends Self Insurance Plans to rely upon the respect to the penalty of perjury that the estimates of the penalty of perjury that I have consolidated report of this self insurer's worker is true, correct and complete with respect to the penalty of perjury that I have consolidated report of this self insurer's worker is true, correct and complete with respect to the penalty of perjury that the estimates of the penalty of	ers' compensation liabilities. To the be- ne workers' compensation liabilities in ature liability of workers' compensation re liability of claims, using prevailing	st of my knowledge and belief this report curred and paid. I further declare under on claims made in this report reflect the
Original Signature of Administrator (Person)	Date	
Typed Name of Administrator	Name of Adm	ninistrative Agency or Employer
Title	Street Addres	ess
	City	State Zip+4
Phone No. of Administrator () area code	FAX No. () area code	
E-mail Address of Administrator		

NOTE: Claims Administrator

Complete this page for **each adjusting** location where there are <u>at least</u> two adjusting locations.

			III. LIABILITI	ES BY REPORTIN	NG LOCATION		
Reporti	ing Locati	on Nos.:					
Name/I	[dentificat	ion of Location:					
Name o	of Master (Certificate Holde	r·				
	f Report:	cermicate Holde					
	•	ort (Due March e	each vear)	Amended Repo	rt Interio	m Report	
	igiliai Kep	ort (Duc March C	acii yeai)	Amended Repo	From	To T	
A. CASES	S AND BE	ENEFITS (to near	rest dollar)		Date: Month Day	Year Date: Mor	nth Day Year
		Incurred	Liability	Paid to	o Date	Future	Liability
	Number	\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical
1. Cases open as of 12/31/2000 reported prior to 1996							
2. Open & Clo a. All cases	osed Cases:						
reported in 1996							
1996 Cases open							
b. All cases reported in 1997							//////////////////////////////////////
1997 Cases open							
c. All cases reported in 1998							<i> </i>
1998 Cases open							
d. All cases reported in 1999							<i> </i>
1999 Cases open							
e. All cases reported in 2000							<i> </i>
2000 Cases open							
						\$ Indemnity	\$ Medical
					SUBTOTAL		
3. ESTIM	ATED F	UTURE LIABIL	ITY (Indemnity pl	us Medical)	TOTAL	\$ Indemnity	\$ Medical
4 Total	Renefits r	said during 2000) (including all ca	se expenditures): .			ψ iviodical
	_	_		000:			•
			_				
7. TOTA	L of 5 and	d 6 (also entered	in 2e above):				
8. TOTA	L numbei	of open indemn	nity cases (all year	s):	• • • • • • • • • • • • • • • • • • • •		
9. Numb	er of Fata	lity cases reporte	ed in 2000:				
				or administrator wa r legal representati			
				oyer or administrato r legal representati			

A. NAME OF CURRENT ADMINISTRATOR(S)/ADMINIS	TRATING AGENCY(S) AT THE TIME OF PREPARING THIS REPORT.
1. Name (Person)	Administrative Agency's
Agency Name	Certificate No.:
Address	or Self Administered
City State _	Zip+4
THIS REPORT PERIOD? \square YES \square NO	PE OF CHANGE: Change in Administrative Agency Change to or from Self Administration
C. NAME OF PRIOR ADMINISTRATOR(S)/ADMINIST	
Agency Name	
Address	
City State _	Zip+4
I declare under penalty of perjury that I have prepare consolidated report of this self insurer's workers' compet is true, correct and complete with respect to the workers the penalty of perjury that the estimates of future liabil	TIFICATION ed or caused this report to be prepared and I have examined this insation liabilities. To the best of my knowledge and belief this report compensation liabilities incurred and paid. I further declare under ity of workers' compensation claims made in this report reflect the of claims, using prevailing industry standards, and the signatory ition.
Original Signature of Administrator (Person)	Date
Typed Name of Administrator	Name of Administrative Agency or Employer
Title	Street Address
	City State Zip+4
Phone No. of Administrator ()	FAX No. ()
area code E-mail Address of Administrator	area code

IV.	RECORDS STORAGE
1. Are claim records stored at any location other than	with the current administrator?
Yes No If yes, Where?	
A. Agency Name	C. Agency Name
Address	Address
City State Zip+4	City State Zip+4
Phone ()	Phone ()
B. Agency Name	D. Agency Name
Address	Address
City State Zip+4	City State Zip+4
Phone ()	Phone ()
V. IN	SURANCE COVERAGE
1. Are any of your workers' compensation liabilities in	
covered by a standard workers' compensation insu	rance policy?
☐ Yes ☐ No If Yes:	
1. Name of Insurance Company:	
Policy Number:	Policy Issue Date:
Policy Number:	Policy Issue Date:
2. Are any of your workers' compensation liabilities in	
covered by a specific excess workers' compensation	n insurance policy?
Yes No If Yes:	
1. Name of Carrier:	
Policy Number:	Policy Issue Date:
Retention Limit:	
2. Name of Carrier:	
Policy Number:	•
Retention Limit:	
3. Do you carry an aggregate (stop loss) workers' cor	mpensation insurance policy?
☐ Yes ☐ No If Yes:	
1. Name of Carrier:	
Policy Number:	Policy Issue Date:
Retention Limit:	
2. Name of Carrier:	
Policy Number:	Policy Issue Date:
Retention Limit:	
VI ODEN INDE	MNITY CLAIMS AND CLAIM LOG
VI. OI EN INDE	WILL COMING AND COMIN LOU

A. List of *ALL* Open Indemnity Claims (<u>by reporting location and by year</u>) reported and with claims (<u>in alphabetical order</u>) is attached immediately following page 7 of this report.

(You may use the form attached or a computer-prepared printout organized in the same format.)

B. Specific Excess Insurance Policy Pages

ATTACHMENTS:

- 1. List of Open Indemnity Claims (See instructions under Section VI.)
- ${\bf 2.\ Specific\ Excess\ Insurance\ Policy\ Pages}$

 			-,	
Complete	this	page	on ALL	reports

			VII. S	ECURIT	Y DEPO	SIT		
Certificate Number:]-							
ame of Certificate Hold	ler:							
. CURRENT TYPE(S)	OF DEPOS	inf	ormation on	each type	e of depo	sit pos	ted with the State	of California ecember 31, 2000.)
☐ Surety Bond (s)				Ori	ginal		Active or	Penal Sum
Carrier Name		Bo	ond #		Date		Cancelled	of Bond
						-		\$
								\$ \$
						Su	rety Bonds Total	\$
Bank Name			Letter of C	redit #		Issui	Type ing/Confirm	Total Letter of Credit Amount \$
								\$
								\$
						Letter	s of Credit Total	\$
Securities Issue Name	Typ R-Regis BE-Book	stered	ID/or CUSIP	# Inter	est Rate	Issı	Date ued & Maturity	\$ Par Value
								\$
								\$
								\$
								\$
								\$
								\$
								\$
							Securities Total	\$
Cash, Certificate (s)	of Deposit							,
Deposit Instit	ution		Account N	umber	Ty _l Cash	pe /CD	Date Deposited	Amount
		+						\$
								\$
		+						\$
					<u> </u>		Cash/CD Total	\$
								

o	~		P-0J v	-	
	Complete	e this r	age on	ALL re	ports.

VIII. DEPOSIT CAI	CULATION
A. Estimated Future Liability (From Line 2 of Consolidated Liabilities on Page 2)	
(From Line 3 of Consolidated Liabilities on Page 2)	
B. Minimum Deposit Factor—Known Claims	
Indicate Minimum Deposit Required	Line BB \$
C. Add Deposit for Current Year:	
(1) Estimated Future Liability (From Line A above) \$	
(2) Less Future Liability of cases prior to 1996 (From Line 1 of Consolidated Liabilities on Page 2) - \$	
\$ Indemnity + \$ Medical	
(3) 5 year total unpaid Future Liability = \$	
(4) One year average unpaid liability (Divide Line 3 above by "5"	') ÷ 5 Line CC \$
(5) Subtotal (Add Line BB and Line CC)	Subtotal \$
D. Total Adjustment for Excess Coverage	\$
Adjusted Total	Line DD \$
E. Total Deposit All Types (Line AA, Part VII, previous page)	Line AA \$
Minimum Deposit Increase Indicated (Line DD—Line AA) Increase is Due by May 1.	\$
Minimum Deposit Decrease Indicated (Line DD—Line AA)	\$ (
report, but in no event later than May 1 of each year. Ci	deposit of security within 60 days of filing of this annual ivil penalties of up to \$5,000 for every 30 days or portion essed by the Director of Industrial Relations pursuant to
CERTIFICATE OF COM I declare under the penalty of perjury that I have examined this Self I belief it is true, correct and complete. I am also aware of our company's	nsurer's Annual Report and to the best of my knowledge and
due as a result of this report.	The property deposit that is
Signature of Company Officer	Date
Typed Name of Company Officer	Name of Company
Title	Street Address
	City State Zip+4
	Phone No. ()

area code

SPECIFIC EXCESS INSURANCE POLICY COVERAGE

None in Claimant Claim No. Date of Injury First Near Reposted To SIP	Certificate N	No:	Name	of S	elf Insurer:					
Name of Specific Excess Carrier Policy Period Policy Per	Note	e: Instructions to Cl	laims Administrator—	-See 1	Reverse Side	of this Pa	age.			
Policy Number	Name of Clain	nant	Claim No.		Date of Injur	у				
Prom: To: Upper Policy Limit S: Upper Policy L	Description of	Injury	·	Nan	ne of Specific	Excess Carr	rier			
Claim Reported to Currier? Claim Acknowledged/Accepted by Carrier? Plate carrier denied any part or all liability of this claim? Total Pad on Claim Finployer's Retention (Indomity & Medical figures from Section VI) S Estimated Future Liability on Claim (From Section VI) Name of Claimant Claim No. Pate of Injury Policy Number Policy Period From: Total Pad on Claim Total Employer's Retention S: Upper Policy Limit S: Claim Reported to Carrier? Claim Recorded to Carrier? Claim Acknowledged Accepted by Carrier? Policy Number Policy Period Employer's Retention (Indomity & Modical figures from Section VI) S Employer's Retention S: Upper Policy Limit S: Upper Policy Limit S: Total Pad on Claim (Indomity & Modical figures from Section VI) Total Uppaid Employer Retention S: Upper Policy Limit S: Upper Policy Limit S: Total Pad on Claim (Indomity & Modical figures from Section VI) Policy Number Policy Number Policy Period From: Total Pad on Claim (Indomity & Modical figures from Section VI) Policy Number Policy Period From: Total Pad on Claim (Indomity & Modical figures from Section VI) Policy Number Policy Period From: Total Pad on Claim (Indomity & Modical figures from Section VI) Policy Number Policy Period From: Total Pad on Claim (Indomity & Modical figures from Section VI) Policy Number Policy Period From: Total Pad on Claim (Indomity & Modical figures from Section VI) Policy Number Policy Period From: Total Uppaid Employer Retention (Indomity & Modical figures from Section VI) Policy Number Policy Period From: Total Uppaid Employer Retention (Indomity & Modical figures from Section VI) Policy Number Policy Period From: Total Uppaid Employer Retention Section VI) Policy Number Policy Period From: Upper Policy Limit S: Upper Policy Lim	Policy Number	er	Policy Period	<u> </u>		Employer	r's Retentio	n \$:		
Claim Acknowledged/Accepted by Carrier? Policy Number Policy Period From: Policy Number Policy Number Policy Number Policy Number Policy Period From: Claim Reported to Carrier? Claim Acknowledged/Accepted by Carrier? Hand of payment by excess carrier to date of this claim: S Total Paid on Claim (Identically seed on Claim (Identical	•									
Has carrier denied any part or all tiability of this claim? Total of payment by excess carrier to date of this claim? Employer's Retention Employer's Retention Minus b. Minus c. Date of Injury Name of Claimant Claim No. Date of Injury Name of Specific Excess Carrier Policy Number Policy Period From: To: Employer's Retention S: Employer's Retention S: Employer Retention S: Total Paid on Chaim (Item c. above) Total Unpaid Employer Retention Total Unpaid Carrier Liability Total Unpaid Carrier Liability Total Unpaid Carrier Liability Total Unpaid Carrier Liability Name of Specific Excess Carrier Policy Number Policy Period From: To: Employer's Retention S: Employer's Retention S: Employer's Retention S: Total Paid on Chaim Employer Retention S: Total Paid on Chaim From Section VI) Lupaid Employer Retention S: Unpaid Employer Retention Frace "O' if "b." is greater than "a." S Total Paid on Chaim Frace "O' if "b." is greater than "a." S Total Paid on Chaim Frace "O' if "b." is greater than "a." Lupaid Employer Retention Frace "O' if "b." is greater than "a." S Total Paid on Chaim (Indemnity, & Minus of Specific Excess Carrier Ves No Total Paid on Chaim (Indemnity, & Madical figures from Section VI) Lupaid Employer Retention Frace "O' if "b." is greater than "a." S Unpaid Employer Retention Frace "O' if "b." is greater than "a." S Lupaid Employer Retention Frace "O' if "b." is greater than "a." S Description of Injury Name of Claimant Claim No. Date of Injury Name of Specific Excess Carrier Policy Number Policy Period From: To: Lupaid Employer Retention Frace "O' if "b." is greater than "a." S Lupaid Employer Retention Frace "O' if "b." is greater than "a." Ves No Total Paid on Chaim (Indemnity, & Madical figures from Section VI) Lupaid Employer Retention Frace "O' if "b." is greater than "a." Ves No Total Paid on Chaim (Indemnity, & Madical figures from Section VI) Lupaid Employer Retention Employer's Retention Lupaid Employer Retention Employer's Retention	Claim Reporte	ed to Carrier?		Ye	s No					
Total of payment by excess carrier to date of this claim: Total Paid on Chaim	Claim Acknow	vledged/Accepted by C	arrier?	Ye	s No					
Total Paid on Claim Firm Policy From From From From From Section VI) Total Unpaid Employer Retention From Section VI) Lipsaid Carrier Liability First Year Reported From Section VI) Lipsaid Employer Retention Li	Has carrier der	nied any part or all liab	ility of this claim?	Ye	s No					
Land Samployer's Retention Minus Samployer Retention Claim Chairm Claim Chairm Chairm Claim Chairm	Total of payme	ent by excess carrier to	date of this claim: \$							
1 a. S Minus b. S Unpaid Employer Retention (tlem c. above) First Year Reported To SIP Name of Claimant Claim No. Date of Injury First Year Reported To SIP Description of Injury Norman of Specific Excess Carrier Policy Number Policy Period From: To: Unpaid Employer Retention Claim School edged / Accepted by Carrier? Has carrier denied any part or all liability of this claim: S Unpaid Employer Retention (tlem c. above) From: Total Unpaid Carrier Liability Total Unpaid Employer Retention Claim Acknowledged / Accepted by Carrier? For Sir Sir Sir Sir Sir Sir Sir Sir Sir Si		Employer's Retention	(Ind	lemnity			on VI)	Er	Unpaid Employer Retention nter "0" if "b." is greater than "a."	
Name of Claimant	1 a. \$				<u> </u>		1			
S	Estima		Claim	Un			1		Total Unnaid Carrier Liability	
Description of Injury Name of Specific Excess Carrier	2 d. \$	(**************************************	Minus e.	\$	(=	f.		
Description of Injury Name of Specific Excess Carrier										
Description of Injury Name of Specific Excess Carrier	Name of Claim	nant	Claim No		Data of Injur			Lingt X	Zoon Domontod	
Policy Number Policy Period From: To: Upper Policy Limit \$: Claim Reported to Carrier? Yes No Yes No Yes Yes No Yes No Yes Yes Yes No Yes			Claim No.		Date of Injury					
Claim Reported to Carrier? Claim Acknowledged/Accepted by Carrier? Has carrier denied any part or all liability of this claim: Total of payment by excess carrier to date of this claim: S Total Paid on Claim (Indemnity & Medical figures from Section VI) Estimated Future Liability on Claim (From Section VI) Name of Claimant Claim No. Date of Injury Name of Specific Excess Carrier Policy Number Policy Number Policy Period From: Total Or payment by excess carrier to date of this claim: Yes No No No No Unpaid Employer Retention (Item c. above) Unpaid Employer Retention (Item c. above) First Year Reported To SIP Name of Claimant Claim No. Date of Injury Name of Specific Excess Carrier Policy Number Policy Period From: Total Unpaid Carrier Liability Yes No Unper Policy Limit \$: Unpaid Employer's Retention \$: Upper Policy Limit \$: Unpaid Employer Retention \$: Upper Policy Limit \$: Unpaid Employer Retention \$: Upper Policy Limit \$: Unpaid Employer Retention \$: Upper Policy Limit \$: Total of payment by excess carrier to date of this claim: **Yes No Total Paid on Claim (Indemnity & Medical figures from Section VI) Employer's Retention Employer's Retention Inter "0" if "b." is greater than "a." **Yes No Total Paid on Claim (Indemnity & Medical figures from Section VI) Employer Retention Enter "0" if "b." is greater than "a." **Unpaid Employer Retention (Indemnity & Medical figures from Section VI) Employer Retention (Indemnity & Medical figures from Section VI) Employer Retention (Inter "0" if "b." is greater than "a." **Unpaid Employer Retention (Inter "0" if "b." is greater than "a." **Unpaid Employer Retention (Item c. above) Total Unpaid Carrier Liability	Description of	Injury		Nan	ne of Specific	Excess Carı	rier			
Claim Reported to Carrier? Claim Acknowledged/Accepted by Carrier? Has carrier denied any part or all liability of this claim? Total of payment by excess carrier to date of this claim: S Minus b. S Total Paid on Claim (Indemnity & Medical figures from Section VI) Lupaid Employer Retention (Item c. above) Name of Claimant Claim No. Date of Injury Name of Specific Excess Carrier Policy Number Policy Number Policy Period From: Total Paid on Claim Total Unpaid Carrier Liability Total Unpaid Carrier? Claim Reported to Carrier? Claim Acknowledged/Accepted by Carrier? Has carrier denied any part or all liability of this claim? Total Of payment by excess carrier to date of this claim: Total Of payment by excess carrier to date of this claim: Total Of payment by excess carrier to date of this claim: S Total Paid on Claim (Indemnity & Medical figures from Section VI) First Year Reported To SIP No Lupaid Employer's Retention S: Upper Policy Limit S: Unpaid Employer Retention Enter "0" if "b." is greater than "a." Total Paid on Claim (Indemnity & Medical figures from Section VI) Estimated Future Liability on Claim (From Section VI) Minus b. Lupaid Employer Retention Enter "0" if "b." is greater than "a." Total Paid on Claim (Indemnity & Medical figures from Section VI) Total Unpaid Employer Retention Enter "0" if "b." is greater than "a." Total Unpaid Employer Retention Enter "0" if "b." is greater than "a."	Policy Number	er								
Claim Acknowledged/Accepted by Carrier? Has carrier denied any part or all liability of this claim? Total of payment by excess carrier to date of this claim: Total Paid on Claim			From: To:			Upper P	olicy Limit	\$:		
Has carrier denied any part or all liability of this claim? Total of payment by excess carrier to date of this claim: Employer's Retention Employer's Retention Estimated Future Liability on Claim (From Section VI) Date of Injury Name of Claimant Claim No. Date of Injury Policy Number Policy Period From: Total Unpaid Employer Retention S: Upper Policy Limit \$: Claim Reported to Carrier? Claim Acknowledged/Accepted by Carrier? Has carrier denied any part or all liability of this claim: Total Unpaid Employer Retention S: Upper Policy Limit \$: Total Of payment by excess carrier to date of this claim: Total Of payment by excess carrier to date of this claim: Total Of payment by excess carrier to date of this claim: Total Of payment by excess carrier to date of this claim: Total Of payment by excess carrier to date of this claim: Total Of payment by excess carrier to date of this claim: Total Of payment by excess carrier to date of this claim: Total Of payment by excess carrier to date of this claim: Total Of payment by excess carrier to date of this claim: Total Paid on Claim (Indemnity & Medical figures from Section VI) Total Of payment by excess carrier to date of this claim: Total Paid on Claim (Indemnity & Medical figures from Section VI) Total Unpaid Employer Retention Enter "O" if "b." is greater than "a." Total Unpaid Employer Retention Enter "O" if "b." is greater than "a." Total Unpaid Carrier Liability Total Unpaid Carrier Liability	Claim Reporte	ed to Carrier?	<u> </u>	Ye	s No					
Total of payment by excess carrier to date of this claim: Employer's Retention	Claim Acknow	vledged/Accepted by C	arrier?	Ye	s No					
Employer's Retention I a. \$	Has carrier der	nied any part or all liab	ility of this claim?	Ye	s No					
Employer's Retention I a. \$ Minus b. \$ Enter "0" if "b." is greater than "a." I a. \$ Minus b. \$ Enter "0" if "b." is greater than "a." I a. \$ Minus b. \$ Enter "0" if "b." is greater than "a." I a. \$ Minus c. \$ Unpaid Employer Retention (Item c. above) Total Unpaid Carrier Liability I a. \$ Minus c. \$ Enter "0" if "b." is greater than "a." I a. \$ Minus c. \$ Unpaid Employer Retention (Item c. above) Enter "0" if "b." is greater than "a." I a. \$ Minus c. \$ Unpaid Employer Retention (Item c. above) Enter "0" if "b." is greater than "a." I a. \$ Minus c. \$ Unpaid Employer Retention (Item c. above) Enter "0" if "b." is greater than "a." I a. \$ Minus c. \$ Unpaid Employer Retention (Item c. above) Enter "0" if "b." is greater than "a." I a. \$ Unpaid Employer Retention (Item c. above) Enter "0" if "b." is greater than "a." I a. \$ Unpaid Employer Retention (Item c. above) Enter "0" if "b." is greater than "a." I a. \$ Unpaid Employer Retention (Item c. above) Total Unpaid Carrier Liability I a. \$ Unpaid Employer Retention (Item c. above) Total Unpaid Carrier Liability I a. \$ Unpaid Employer Retention (Item c. above) Total Unpaid Carrier Liability I a. \$ Unpaid Employer Retention (Item c. above) Total Unpaid Carrier Liability I a. \$ Unpaid Employer Retention (Item c. above) Total Unpaid Carrier Liability I a. \$ Unpaid Employer Retention (Item c. above) Total Unpaid Carrier Liability I a. \$ Unpaid Employer Retention (Item c. above) Total Unpaid Carrier Liability I a. \$ Unpaid Employer Retention (Item c. above) Total Unpaid Carrier Liability I a. \$ Unpaid Employer Retention (Item c. above) Total Unpaid Carrier Liability I a. \$ Unpaid Employer Retention (Item c. above) Unpaid Employer Retention (Item c. above) Total Unpaid Carrier Unpaid Employer Carrier Unpaid Employer Carrier Unpaid Employer	Total of payme	ent by excess carrier to	date of this claim: \$							
Estimated Future Liability on Claim (From Section VI) Minus e. Minus e. Date of Injury Name of Claimant Claim No. Date of Injury Name of Specific Excess Carrier Policy Number Policy Period From: To: Employer's Retention \$: Upper Policy Limit \$: Claim Reported to Carrier? Claim Acknowledged/Accepted by Carrier? Has carrier denied any part or all liability of this claim: Total of payment by excess carrier to date of this claim: Employer's Retention (Indemnity & Medical figures from Section VI) Estimated Future Liability on Claim (From Section VI) Minus b. Unpaid Employer Retention (Item c. above) Total Unpaid Carrier Liability Total Unpaid Carrier Liability Total Unpaid Carrier Liability Total Unpaid Carrier Liability		Employer's Retention	(Ind	lemnity			on VI)	Er	Unpaid Employer Retention nter "0" if "b." is greater than "a."	
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2 d. \[\\$ \] \ \ Minus e. \[\\$ \] \ = f. \[\\$	Estima		Claim	Un			1		Total Unpaid Carrier Liability	
	2 d. \$		Minus e.	\$			=	f.	\$	

Instructions to Claims Administrator

Complete all the information requested on each claim that has estimated incurred liability greater than the minimum retention level of the specific excess insurance policy.

Add the subtotaled carrier liability for all pages necessary to list the claims in excess coverage and then complete the back-side of this form on the last page of the specific excess insurance policy coverage pages in order to calculate the adjustment figure of Specific Excess Coverage to enter on Page 6, Line D of the Self Insurer's Annual Report.

Submit the completed page or pages as Section B of the Part 6, List of Open Indemnity Claims, for each Annual Report.

Note: You may use this form or a computerized form displaying the same information in the same format.

Calculation of Specific Excess Coverage Entry for Annual Report:		
1. Total of Carrier Liability Listed on All Pages of "Specific Excess Insurance Policy Coverage" pages attached hereto:	\$	
2. Enter Deposit Rate Applicable for This Self Insurer:	X	

4. Enter Adjustment Figure on Line 3 above on Page 6, Line D.

3. Multiply Line 1 Figure times Deposit Rate and Enter Specific Excess Insurance Adjustment:

Page of_	Pages
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LIST OF OPEN INDEMNITY CASES

AS OF_				
(D	Date)			

Reporting Location No.:	All Cases on this Page are
Certificate Number:	For the Year
NAME OF MASTER CERTIFICATE HOLDER:	

ame of Insured or Deceased		Description of Injury	Paid t	o Date	Estimated Future Liability		
Last) (First Initial)	Injury		\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical	
ist Alphabetically within year)							